4

Developmental–Relational Therapy with Traumatized Teens

James was a depressed and lethargic thirteen-year-old boy who had almost given up when I first met him. I treated James through some death-defying experiences, two psychiatric hospitalizations, a tough court hearing, and the day he discovered something that gave his life meaning and it began to get better. Although it's been a long time since we first spoke, I remember that first hour vividly; I can still see him shuffling slowly, reluctantly, into my office. He kept one earplug in, the other draped around his neck, blaring Metallica, a band that the disenfranchised boys on my caseload once loved so much I could recognize the sound through one distant earbud.

James barely acknowledged me, seeming mesmerized by his trailing shoelaces; he acted like he was on a forced death march into my sunny, welcoming office. He sat on the couch, as far from me as he could manage, screwing his knobby knees into the side, so none of him was pointing in my direction. Crumpled over, he began picking at the shredded bottom cuff of his jeans and flicking little threads onto my floor. *Disengaged and annoying,* I thought, instantly anxious about what was about to happen—along with a deep and heavy sense of how hurt he must feel to be greeting me this sad way.

I slowed my own pace down, trying to get some control over my energy and nerves. *Be less overwhelming,* I told myself, already hooked. I asked a few questions, pausing and breathing into the spaces between. I noted with

relief that James didn't shut me out completely, although he ventured only terse responses that were perhaps as much as he could muster. About twenty minutes in, I gently shared my own experience of sitting with him there. I wondered tentatively about his guardedness, acknowledging how much all of this must suck—including, I imagined, being ordered into therapy with some nosy, middle-aged, hippie lady like me. I said I could understand if he didn't want to be doing this. I told him that I would take some responsibility for making it more fun for him, since he was pretty much mandated to be here—which also probably sucked.

James didn't respond to my query with words, but he glanced up at me, dark, startled eyes filling with tears, before looking away even more fiercely than before. I knew he was lonely and frightened, and I had an inkling about some of the reasons why. I also understood then, too, that he was fragile as a teacup; I wouldn't expect to engage him in "real therapy" for many weeks to come. First, we had to find a safe way to be together in the room. That day we began to play Rummy 5,000—an epic version of the traditional card game, requiring multiple therapy sessions to complete, and, not incidentally, moving James's body, mind, and focus gradually in my direction.

I saw James for more than three years. For the duration, his father was in prison for multiple serious offenses, and they had no contact. James's opiate-addicted mother came and went, sometimes in jail, sometimes trying hard to get clean, often unavailable, and ultimately a tragic disappointment. Initially, James could visit her when he wanted to, or when she was interested in seeing him; at one point, before losing custody permanently and moving far away, she joined us for a few sessions. It was helpful for James's healing that I saw both her remnant love for him and her heartbreaking limitations.

James lived mostly with his grandmother, who had gotten temporary guardianship of him the year before. When she was exhausted or unwell, he'd stay with his aunt and uncle an hour away. This was not a perfect arrangement, but it offered more stability than he'd had previously in his life. He was struggling academically for the second time in the seventh grade and, because he was sleeping so poorly at night, he snoozed through many days in school, making it impossible to keep up. The overwhelming combination of his chaotic family life, a reading disability, the move to a new junior high school, and his own relentless depression had taken quite a toll on his motivation. But without a safe relationship, I couldn't help him with any of that.

DEVELOPMENTAL–RELATIONAL THEORY

In recent years, scholars studying IPNB, adolescent development, and relationships of all kinds have arrived at similar conclusions regarding

the importance of attachment bonds across the lifespan and the significant role of an attachment relationship in psychotherapy (e.g., Greenberg, 2010; Jordan, 2010; Siegel, 2012a). Current thinking about psychological growth and healing emphasizes human interdependence and connection, rather than separation and individuation, even during adolescence. It's now widely agreed that the self develops in the context of relationships; the compelling existential truth—particularly vital for anyone working with teens to consider—is that a coherent identity emerges only in connection with others. These dynamic models of psychological well-being appreciate that authentic caring relationships provide the keys to optimal development, and nothing else will do. Disparate scholarship converges in describing what we've probably known in our hearts all along: the salutary effects of early attachment security on brain development, emotional regulation, the capacity to form and sustain other relationships, and overall health over the lifespan. Love is good.

Developmental–relational theory provides the evidence-based rationale—drawing from attachment research, the study of contemporary adolescence, and IPNB—for the value of secure love in therapy with traumatized teens like James. It offers an integrative framework for why and how to pay steady, benevolent attention to someone who may never before have had anyone's steady, benevolent attention. In its emphasis on right-hemisphere attachment and feelings, this approach reflects a set of values that are distinct from more cognitive-behavioral approaches; in its reliance on the slow, hard work of corrective relational experiences, it also distinguishes itself from other, more technique-driven and solution-focused models. With traumatized adolescent clients, it is emotion that gradually changes emotion—not rational explanation or interpretation, not snazzy techniques or "fake it till you make it" exhortations. Indeed, while I offer many suggestions for "things to do" in therapy in the following pages, I am under no misapprehension that these strategies constitute "techniques" much beyond their utility in forming, maintaining, and repairing the strongest possible therapeutic alliance.

To facilitate healing connections inside themselves and with others, the overarching goals of developmental–relational therapy (DRT) for traumatized teens include feeling safe in a relationship; acquiring the hardiness and skills to seek and sustain attachments even in the face of inevitable ruptures; experiencing and recognizing a range of powerful feelings; relying on others to regulate, and then learning to self-regulate these feelings; and developing empathy and self-compassion.

Because we are adults working with kids, DRT does not, strictly speaking, strive for the more symmetrical power arrangement that is generally emphasized in contemporary relational work with adults. Yes, we want to be collaborative, to co-create a therapy we do *with* and not *to* our young

clients. However, we must be willing and able at times to step out from behind our neutral stance and really show up as concerned adults do. It seems to me that, for so many of these kids, the real ADD is *adult-deficit disorder*; this fictional diagnosis would be determined by the adverse developmental impact of adult inattention.

Implicit in this therapy, too, is an understanding of adolescent development with all of its distinctive virtues and challenges. Perhaps what we have most to offer our young clients is our well-regulated, fully developed, two-sided adult brain, with its mature capacity for awareness, perspective, appraisal, curiosity, and forgiveness on full display. We make and sustain connections, we repair inevitable ruptures, we provide the safe haven and secure base. In DRT, we are both the mechanism of change and the intervention. Because *we* are the adults in the room, *we* are responsible for what happens in treatment.

Therapy between Right Brains

I've described earlier how the brain's right hemisphere processes and stores information and experience in distinct and important ways. Of particular relevance to DRT is the confluence of evidence that attachment experiences, including attachment trauma, develop in the right hemisphere. Schore (2003) discusses persuasively how healing trauma is mostly a right-brain-to-right-brain activity—connecting to our deepest emotions, largely outside of conscious awareness of the left hemisphere. As host to the "three R's"—relationality, regulation, and resilience—the right hemisphere is arguably the foundation for all subsequent exploration, learning, and growth. DRT keeps us attuning and reattuning to the adolescent in the moment because only through new healing experiences can the teen's right brain learn to fire and rewire for safety and intimacy.

The logic for this approach is as follows: It is clear that early moment-to-moment troubled interactions with unpredictable and dangerous caregivers created attachment trauma in the first place. Still, we continue to learn from relational–emotional experiences over the years, perhaps especially through adolescence and young adulthood, when neurodevelopmental changes are again dramatic and rapid. The developing brain is malleable; current felt experiences of safety can be transformative to brain, heart, and behavior. Safe interactions with reliable adults are corrective, offering adolescent clients novel ways of feeling and being in relationships. The concept of neuroplasticity is foundational. When we can create for our clients new experiences of how it feels to be connected to someone dependable and caring, our adolescent clients' brains start to change and they begin to live differently in the world.

The Adolescent Right Brain Is Open for Business

The child's left hemisphere "comes online" at about eighteen months of age and then starts developing rapidly. It takes over at about age three and remains dominant through the lifespan *except during adolescence*. During this time, while the cortex is undergoing a profound remodeling, the adolescent is actually using the right hemisphere more for engaging in the world and problem solving. Through these years, the adolescent brain "goes limbic," and it's potentially a great thing for therapy.

Consider some of these elements of brain development that make therapy particularly advantageous for adolescents: They crave s*timulation* and *novelty*. Our clients may be uniquely suited for therapy's opportunities for creative exploration and new perspectives. We therapists are probably not as thrilling as skydiving or binge drinking, but for a traumatized teen, our attention and concern are novel indeed—and plenty challenging in their own way. Teens are also transitioning from the more unitary consciousness of a child toward the multiplicity of awarenesses available to the adult mind. This transformation into more abstract and metacognitive thinking makes our shared exploration of *possibilities,* including *possible selves,* developmentally suitable, and, in varying proportions, both exciting and frightening for them. Furthermore, adolescents want to be in the *company* of others with an intensity that is unparalleled in any other developmental period. We tend to describe this in terms of a huge drive to be with peers, but we shouldn't forget that teens are also highly motivated to be with invested adults who have something to offer.

Moreover, the increased *emotionality* we see in adolescents can—and should—be utilized in the service of treatment, not suppressed, sidestepped, or "managed." To be sure, only adults can reason like adults, which is why we need to accept our teen clients—and their emotional brains—just as they show up in our offices. That is also why the focus on affect and somatic experiencing makes so much sense here; it's what the adolescent is doing anyway. Finally, along with their emotionality and quest for edgy experiences, adolescents are also looking for safe *regulating containment* from adults. The DRT therapist takes seriously the concept of loving limits.

Trauma Is Stored in the Right Brain

Adding to the rationale that more emotional and relational approaches make sense for adolescents in general, there is also ample evidence that traumatic memories are stored in the right hemisphere, including, for example, panic, flashbacks, and somatic trauma memories. This is particularly true for our patients who were traumatized before they even had an operating

left brain. But there is also evidence that right-brain interventions make sense for all kinds of trauma.

It is helpful to tell our clients that their symptoms are "body memories." Indeed, it would be a lot easier for us all if the adolescent understood how and why she was triggered by certain smells, or movements, a particular time of day or year, a tone of voice, or a change in schedule. But that would mean she had explicit left-hemisphere memories—relatively rare for teens with attachment trauma. It is helpful to think of these somatic and affective experiences as sensory equivalents, what Janina Fisher (1999) has called "feelings flashbacks" (p. 3).

The Unconscious Mind Is a Terrible Thing to Waste

Interestingly, the right brain and the unconscious mind share many features. For example, they do not mediate experience with language—they communicate nonverbally; they are atemporal and do not distinguish between past and present; they are emotionally directed; they attend most of all to relationships; they lack insight and self-awareness; they are experienced in the body; they are full of imagination, and make generalizations from experiences (e.g., Schore, 2012; Valent, 2012). Most modern therapy with teens treats the unconscious mind as irrational or a distraction from the important, conscious, problem-solving work they need to do. But for teens with developmental trauma, most of their right-brain strategies for living and surviving are not volitional in a way that gives them access to logical processing. Consider the response you're likely to get to questions like these: "What were you thinking?"; "What made you do that?"; "How will you do this differently next time?"; "Can you tell me about your triggers?"; "Why does that kid make you so angry?"; "How do you feel about that?" When teens tell you simply, "I don't know," this is probably not some strategy of resistance, but the truth.

There is interesting science behind their evident bewilderment. Consider that about 90 percent of the input to the cortex comes through the fast, internal implicit system, which processes information a "vital half second" ahead of conscious awareness. This means that by the time they know they've had an experience, their right brains have already had the opportunity to construct present knowledge based on a template from the past. In fact, this event under consideration has already been processed many times, activating complex patterns of behaviors and triggered memories. In other words, we might feel we are living in the present but we are actually living a half second behind (Cozolino & Santos, 2014). Therapy can be useful in the catch-up process, as it integrates language and thinking with body experience and feeling. But that can take awhile, and "I don't know" is often a very honest first answer.

Still, it's important also to understand that the survival of our teen clients has probably been enabled by this lack of conscious awareness. It's not irrational that they have symptoms they can't understand; it's adaptive. Body memories can keep the trauma alive and informative, while protecting our teen clients from the full conscious knowledge of it. Being respectful of the unconscious doesn't mean we have to put kids back on the couch and do dream analysis (although access to dreaming can be really important to healing). It does mean that we should respect all kinds of "knowing"—whether it's in the body or in the mind. It also means that we need to engage our own unconscious process more than we might want to, or might feel comfortable doing. We have many ways of "knowing," too, and DRT requires that we make use of all of them.

THE FOUR M's OF DRT: MIRRORING, MENTALIZATION, MINDFULNESS, AND MODULATION

DRT is fundamentally about showing up as an authentic adult in an intentional relationship with a traumatized adolescent. The empathic therapeutic stance has to be cultivated and practiced. Paying heartfelt attention to someone with an abundance of conscious and unconscious strategies for disconnecting is hard work. Even the most relational therapist operates within cycles of attuning and disconnecting. The "four M's" of DRT describe the core elements underpinning this kind of intense therapeutic focus.

Mirroring

The mirror neuron system is the source of our capacity for empathic attunement. We see a spider crawling up someone's arm, and we get that creepy-crawly feeling. Similarly, we have the wiring to experience someone's sorrow or joy as if it were our own. When we are sitting with a distressed adolescent, our mirror neurons simulate their dysregulated mental state, and we can feel something like that in our own bodies. In optimal circumstances, we can then use this somatic information to consider labels for it—we check in with ourselves and sense that it's likely to be at least one of those deep attachment-based affects: anger, sadness, fear, confusion, terror, surprise, disgust, joy, and/or excitement. We may apply such words to these feelings and offer the experience back to the teen in different ways—through facial and body language, naming, inquiring, describing. Neuroscientists call this a "bottom-up" process—at lightning fast speeds, we perceive someone's emotional state, our mirror neurons fire, our bodies/feelings change, we may notice that physical change, and then we label the feelings (e.g., Iacoboni, 2008).

Nevertheless—especially in therapy between highly empathic adults and adolescents who may not know they are having a feeling at all—the process of empathic mirroring gets a bit more complicated. In some instances, we get to the step of noticing a physical change in ourselves, and then we feel a little confused. This "empathy contagion" can make it hard to know: "Is it you or is it me that I am feeling?" (Bohart & Greenberg, 1997). In fact, my experience has been that empathic experiences can be a little of everything—projective identification; my own feelings about myself, about the client, about us together; her walled-off affect; and also real empathy at its finest. The ingredients of feelings of empathy might not always be clear, so it's very useful to bring our awareness to this question.

And, interestingly, in this work, we don't just mirror affective engagement; we should also expect to experience the teen's apathy, boredom, disconnection, and drift. So when we recognize these internal shifts in the moment, toward or away from our clients, we need to ask ourselves, "Why am I feeling like this?" Like them, we also may not have a clue, or we may be quite aware of whatever particular emotional energy is in the therapy room that day—including our own stuff. But without this effort, we will likely miss an opportunity for using the experience to reattune with the adolescent. In DRT, mirroring is one of our most useful ways of "knowing" what is happening in the relationship; it's a tool we can carry into every session, and it gets sharper with use. But it's only as effective as our ability to first connect with our own emotions and try to sort out how we're feeling at the time.

In healthy development, babies and toddlers have frequent daily experiences engaged in the dance of attunement. Their caregivers look at them with an adoring gaze and reflect back, often with amplification, what the baby is feeling. A little infant smile evokes a broad grin in the caregiver, a startle causes the adult to knit eyebrows, and react quickly. When a toddler falls, parents may say, with a sad downturn at the mouth, "Ohhh, that must have hurt, *a lot*!" This early mirroring has some magnification in it, perhaps designed by nature to make sure these early feeling experiences get registered and named for the infant. Importantly, an attuned caregiver shows the baby how the baby is feeling—not how the caregiver feels. Over time, a securely loved child comes to learn what she's feeling because she's seen it mirrored compassionately in the faces of caring people. She knows what it is to "feel felt," and as a result she comes to know her own affective world. It may seem counterintuitive, but the mind develops from the outside in. In other words, we gain a sense of identity—including how we think and feel about ourselves, and our relationships—by our mirrored experiences with caregivers, beginning on day one of our lives.

But the traumatized adolescents in our care have typically had very limited exposure to empathic mirroring. Hypervigilant, they may also be

defended against seeing their experience reflected back; they're ashamed of their vulnerability, fearful of exploitation. And, of course, the kind of emotional amplification we typically offer to little children might appear inauthentic or cheesy to a teenager. Even though it can be unfathomably hard for some of these adolescents to endure the bright light of loving attention, this gently mirrored, recognized, and shared affect is still, over time, the superglue of DRT. Indeed, the multilayered emotional communication we'll have with a teen takes us well beyond mirroring; together we create our own transformative experiences that are much richer than mere one-way reflection.

I remember one session with James, for example, in which he was talking in a remote and factual way about his loneliness, something he experienced even when he was practicing tricks with other skaters at the park. Tears welled up rather quickly and unbidden in my eyes. He asked suspiciously, "What are *you* crying about?" I asked him if he thought he might be experiencing that loneliness in his body, and that maybe I was feeling, too. He became fidgety and uncomfortable. I asked further if he noticed it was kind of sad in the room now. He looked at me, sighed, and said, "You have no idea." I took a deep breath, nodding slowly in empathic agreement. We slumped silently together under the weight of this sadness, and then, as sometimes happens, it lifted away. He sat upright and his affect brightened. James had "felt felt," and that seemed to help him know he wasn't alone.

Mindfulness

So much has been written in recent years about mindfulness in psychotherapy that it now crosses paradigms, and mindfulness can be a part of every sort of practice, from the most cognitive interventions to the most dynamic (e.g., Allen, 2013; Germer, Siegel, & Fulton, 2005; Siegel, 2010a). There are demonstrated benefits to developing mindful practice for therapists (e.g., Epstein, 1995; Fulton, 2005), for clients (e.g., Kabat-Zinn, 2005; Linehan, 1993), and as a shared therapeutic endeavor (e.g., Brach, 2003; Surrey, 2005). Many different treatment approaches have also successfully incorporated mindfulness elements into therapy with children and adolescents (Burke, 2010). In all of these variations, mindfulness can be most simply defined as (1) awareness, (2) of present experience, (3) with acceptance (Germer, 2005).

While mindfulness meditation is often practiced within groups of like-minded individuals, it is usually a deeply personal and internal process of exploration. People come to feel more focused and interconnected as a result of their own independent mindfulness practices; it's typically a private endeavor with demonstrable social benefits. In DRT, as in all mindfulness practices, we'll be developing our capacity to pay sustained

attention. However, here, the object of our mindfulness is the connection with the adolescent. DRT can be viewed as a kind of *co-meditation* practice in which both therapist and the adolescent client are learning to pay attention, in the moment, with acceptance, *to the experience of being together.*

Throughout the therapy relationship, then, we are supporting adolescents to be present with feelings, and with us. We cultivate this co-mindfulness through our own capacity to remain attuned and connected in three ways. First, we are attentive to moment-to-moment changes in our own sensations, feelings, thoughts, and memories. We are also focusing on the experiences of the adolescent, both verbal and nonverbal—their sensations, feelings, thoughts, and memories. And we are noticing the flow of the relationship, including the waves of connection and disconnection, attending to the energy, texture, and emotional qualities of being together. We don't have to comment on everything we notice, but we are training our attention on being together, here and now.

With traumatized adolescent clients, we strive to engage them collaboratively in this process of mutual attention and mindfulness in the moment, to the best of their (and our) abilities. But at least at first, many will quickly become flooded, shamed, and dissociated; they may disconnect even at the very suggestion of sitting still long enough to pay attention to difficult feelings, or "being here, right now" in the room. The last thing they may want to do is be present in their lives in that way, on purpose. Indeed, survival may have taught them instead to value "mindlessness"—for the safety from dark and lonely places they might encounter if they sat still.

So mindfulness is a practice for both of us, and we're in it together. We extend the invitation to co-meditation through our own developing capacity to pay attention, returning our awareness to the ever-changing connection over and over again. We model and enact this process, helping our adolescent clients become more present with us and in their lives, if only for a few moments at a time.

Mentalization

Mentalizing—holding mind in mind—readily accompanies mirroring and mindfulness in therapy; it describes more specifically the way we pay attention to mental states in ourselves and in others. Mentalizing is both entirely natural—every adult with a secure attachment can do it—and also quite complicated (Allen, 2013; Fonagy, Gergely, Jurist, & Target, 2002). For example, we know that our minds are distinct from those of others, and we can't ever know someone else's mind the way we do our own. This makes mirroring an important element; we can guess how other people are *feeling* with much greater accuracy than what they are *thinking.*

But explicit mentalizing is usually conscious and deliberate. We mentalize when we put feelings into words and when we tell stories about why people feel, think, and behave the way they do, including ourselves. We may also mentalize more implicitly; for example, when we take turns in conversation, or when we make adjustments in our tone and posture if we are speaking to someone who is upset (Allen, 2013). And mirroring and mentalization are part of the same empathic process; in therapy, we are mentalizing continuously, as we bring unconscious experiences into conscious awareness through naming, meaning making, and helping our traumatized clients to develop a more richly textured understanding of themselves in relationships.

In healthy families, children learn to mentalize from their parents or primary caregivers. There's a robust and fascinating research literature demonstrating the connection between a parent's capacity to mentalize and secure attachment in children. Securely attached parents are able to mentalize about their own attachment history—with coherent narrative and emotional engagement—and are much more likely to be able to mentalize about their infants' attachment needs and emotions (e.g., Fonagy et al., 2002; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005).

It is perhaps no surprise, then, that our insecurely attached and emotionally dysregulated adolescent clients so often have such difficulty mentalizing. They likely had caregivers whose misattunement was marked by frightened and frightening behavior, responding with hostility, indifference, or confusion to them early on. Parents' own trauma histories may have been activated by seeing their infant's distress. To put it mildly, it is very unlikely these abusive and neglectful caregivers were able to mindfully consider the infant's mind. Consequently, and as Fonagy, Gergely and Target (2007) conclude, attachment trauma impedes the development of mentalization in significant ways, including, for example, difficulty appreciating what others are thinking and feeling, limited capacity to talk about mental states, trouble understanding emotions, diminished empathy with other children's distress, and notable difficulty managing their own emotional dysregulation. Their impaired capacity to mentalize is associated with a broad range of relational problems, and this creates additional obstacles for progress in treatment.

The relationship between mentalization and regulation is particularly important for the work we do. Children learn to regulate distress at least in part through mentalizing interactions. Mentalization helps them understand that others will be there for them when this is so, and it supports their ability to identify feelings and figure out what to do next. Developmental trauma stems in some part from mentalizing failures—the child is left psychologically alone in unbearably painful emotional states (Allen, 2013). In DRT, we support teens' capacity for mentalization by helping them pay

attention both to their own minds, and, when contemplating social interactions and relationships, to the minds of others. We do so through reflection in the moment, development of coherent narrative, and the generous sharing of our own capacity for mentalization. We might ask, for example: "Do you want to know what I think?" or "I wonder if it's worth looking at this from another angle, too" or "Is this how you see it?"

Modulation

The fourth "M" in DRT, modulation, describes how we loan our well-regulated adult brain to distressed adolescents to help them feel more emotionally centered and present. When we modulate affect in the room, we may be working to modify its intensity or duration, or to refine the affect so it becomes more manageable (Fonagy et al., 2002). We pay empathic attention to emotion in order to develop a sense of whether we need to bring the energy in the room up or down. Modulation might mean activating emotional intensity that the client has been holding tightly, or, conversely, reducing it by conveying acceptance and support.

In healthy families, babies learn affect modulation through co-regulation within the context of an attachment relationship. They literally learn what it feels like to be held, so that, later on, they have the capacity for self-comfort; they can then know how to "hold" themselves together under stress. Thus the development of effective, flexible self-regulating skills is entirely dependent upon the child's previous experience with safe and reliable relationships.

Recall that the infant's primary attachment strategy is seeking proximity of a caregiver to help with regulation. It's important to note that many adolescents with developmental trauma can't seek out comfort or self-regulate flexibly, but, instead, they have developed rigid auto-regulation strategies, like dissociation, that don't require anyone else and that operate outside of conscious volition.

It stands to reason that most of the adolescents in our care do not even really know what regulation feels like. They can't "self-soothe" in the way we want them to because they simply haven't had sufficient experience with being both present and calm in relationships. The secondary strategies for regulation that they've acquired—becoming hyper- or hypoaroused—are automatic in the service of survival, but such strategies impede new learning and connecting. Through repeated efforts to bring them into their own bodies and into the relationship with us, we can help them learn to recognize and begin to tolerate more comfortable affective states. Only through this repeated experience of co-regulation can they reduce dissociative coping and learn new ways to hold themselves together when they feel they are falling apart.

The assumption here is that our adolescent clients cannot modulate emotions on their own, and so they require our active engagement to learn how through the actual experience of becoming calm and present with us, in real time. We pay attention—via mirroring, mindfulness, and mentalization—to the emotional energy in the room. We work to this end mostly within what Siegel (1999) has called the "window of tolerance"—that comfortable zone of autonomic and emotional arousal that feels optimal for well-being and effective functioning. Falling between the extremes of hyper- and hypoarousal, this is a zone within which "various intensities of emotional and physiological arousal can be processed without disrupting the functioning of the system" (Siegel, 1999, p. 253). When arousal falls within this window, the adolescent is able to make sense of information she's getting from her body—as well as from the therapy relationship. When we push too hard to engage, or fail to contain overwhelming affect, she will become, or remain, dysregulated.

Our adolescent clients generally begin therapy with an extremely small window of tolerance. They have either too much arousal, or too little, or they bounce between these extremes. We try at first simply to modulate dysregulated arousal so we can help our adolescent clients become aware of what regulation even feels like. As we develop a safe and trusting connection, however, we will want to open this window wider, so that they can stay present with us as they begin to explore their traumatic stories, repressed emotions, dissociative states, and experiences of interpersonal disconnection. In a similar vein, Bromberg (2013) describes the most effective therapy as "safe but not too safe." Indeed, it's inevitable that we'll regularly hit or exceed their limits as we push open the window of tolerance. But the more our clients are able to use us to co-regulate, the more room we'll have to work and play at that productive, anxiety-provoking, and exciting edge of awareness, integrating previously dissociated emotions, and, with our support, expanding and deepening their affective range and vocabulary.

CONNECTION AND AUTHENTIC EMOTION

Recall that isolation—including emotional isolation—is traumatizing for human beings; our brains seem to react to it as real danger. Even though we all feel alone some of the time, it seems likely that most psychopathology results in some part from the experience of chronic disconnection (e.g., Jordan, 2010) The challenge for us, however, is appreciating that, while this disconnection is developmentally disruptive, it has also protected our clients from additional harm; in all likelihood, previous attempts to be authentic and vulnerable with significant others have resulted in severe

psychic pain. Adolescents with developmental trauma, then, arrive at our doorstep with a true dilemma: their sense of isolation is the source of both safety and terrible, soul-sapping loneliness.

To facilitate healing connections within themselves and with others, the overarching goals of DRT for traumatized teens include feeling safe in a relationship; acquiring the hardiness and skills to seek and sustain attachments even in the face of inevitable ruptures; experiencing and recognizing a range of strong and powerful feelings; relying on others to regulate, and then learning to self-regulate the experience of strong feelings; and developing empathy and self-compassion. We can help accomplish these objectives through the use of DRT with the following strategies.

Foster Dependence

This therapy relationship is an attachment relationship, and as such it supports our adolescents with a fundamental expectation for effective dependence. We want to become more adaptive attachment figures than they have had in the past, helping them *earn* attachment security with us. To this end, we strive to be the most reliable attachment figures we can: dependable, attuned, available, helpful, forgiving, flexible, and self-aware. We want to help the adolescent experience himself in relation to others in a new way. And we have to try over and over and over again. We're creating new circuits to overwrite and add to the old ones, and such integration—explicitly attending to the right hemisphere while engaged in left-hemisphere naming and organizing—takes time. We need to enact dependability until they get it. We say: "Next week, same time"; "You can call or text me if you need me during the week"; "I was thinking about you"; "Here's the poem I was telling you about"; "I'm so glad to see you, I missed you"; "I'm here for you, even if your body is not so sure that's true."

Keep It in the Room

Whenever possible, bring the conversation into the present. In this work, we privilege the relational-emotional experiences in the moment over all other topics. As much as possible, the real-time connection between therapist and adolescent takes precedence over the other relational experiences in their lives—indeed, over most other kind of stories they are telling about what's happening outside in the "real world." We make that focus explicit, bringing it back into the moment. We note, "People made you mad today; am I making you mad?"; "It seems you're expecting me not to understand this since your teacher didn't. I imagine that's pretty frustrating right now"; "I'm feeling confused; are you?"; "Where are you feeling that in your body?"; "My stomach just clenched a little hearing that"; "Why do

you think I asked you about this?"; "What do you imagine it will it be like after you tell me?"; "I'm feeling touched/sad/scared/happy as I hear you say that"; "What happened right now when you laughed at that?"; "I'm here; you are not alone"; "You seem pretty fidgety today; can I help?"; "I am with you"; "It *is* scary"; "You are safe"; "We're not connecting well right now, and I want to do better"; "That is hilarious; tell me more!"; "What are you experiencing right now, here with me, as we sit together?"; "What do you see when you look at my face?"; "I wonder if you are feeling this, too?"; "I'm so moved that you are able to tell me this"; "Can we sit here together, feet on the ground together?"; "I'm feeling a little worried about you, is it okay if I say so?"; "I think I just missed the boat on that one, I'm so sorry; can we try again?"; "What was it like to hear me apologize to you?"

Repair Quickly

All therapists—no matter how well trained, how deeply present and compassionate, or how skilled—miss a lot. It is simply impossible to pay attention to and "get" another person all of the time. Fortunately, rupture and conflict are not only inevitable, but also crucial to development in therapy. This is not to say you should intentionally show up late, or contrive some issue so you can resolve it. No need for that: you *will* screw up sometimes, without even trying. The important treatment element here, however, is to acknowledge when you realize you're not in sync, even if it's minutes or possibly weeks later. Do not hesitate to try and try again, no matter how trivial the lapse might seem to you.

A few years ago, I worked with a young man whom I once addressed by his younger brother's name. (Years later, I'm still defending myself in my head: seriously, their names rhymed, like *Jon* and *Don* do). He winced when I misspoke, so I could tell that this error really affected him, but I let it slide—along with our connection for most of the rest of the session. In my semiaware mind, I thought, *People make mistakes; this one is small*. But for this teen, my mistake and my disregard were still hurtful, perhaps tying into a lifetime of feeling unseen and unimportant. With just a few minutes left to go, I started to repair, and asked about the moment of rupture, also apologizing for not apologizing sooner. He remained a little grumpy, but came back the next week to try with me again, which he might not otherwise have done. And I worked harder to notice the next time he showed me that we weren't in sync.

The truth is that misattunement is simply inevitable. But we can take some solace from the work of Ed Tronick and his colleagues, who minutely observed interactions between infants and their mothers. This research demonstrates that even the best parents get it wrong a *lot*: on the first try,

they can miss the baby's signals a staggering 70 percent of the time—and still end up with securely attached kids (Tronick, 2007). As with therapy, the interesting part isn't the misattunement; it's what happens next. Tronick's research demonstrated that the infant's emotional regulation was actually *enhanced* by ruptures that were followed by repairs. Babies with this experience develop greater mastery of their dysregulated states and an increased sense of safety and security in relationships. Within that dance of attunement these early missteps and corrections generalized to other relationships, too. And of course, sustained intimacy is only possible for people who are capable of resolving inevitable conflict.

But the traumatized teens we treat usually have long histories of rupture without repair. I may have been the first adult who ever apologized to them. They have precious little tolerance for the hard work of trying to make a relationship better. One of the common outcomes of developmental trauma for adolescents is a microscopically short fuse for rejection, disappointment, failure, or emotional abandonment. They physically experience a call for whatever secondary strategies they've developed to regulate in the face of this too-familiar sense of disconnection, perhaps most notably the flight response that advises their bodies to "Run fast, and don't look back." This means that the effort to reconnect after a rupture, no matter how small and seemingly inconsequential, is *100 percent ours to make*. Resolving conflict and reattuning are fundamental to this work, so we absolutely need to face disconnection when we feel or know it happened.

We say, "I shouldn't have interrupted you"; "It wasn't respectful of me to keep you waiting"; "I'm really struggling here, and I can tell I'm not getting it at all"; "I'm so grateful you're willing to keep trying to tell me what's going on"; "I was a kid a long time ago, so I need to have things explained to me that would make it easier if I knew." We find the courage to apologize—"I'm so sorry, please forgive me"—and then we try to fix it any way we can. We get better doing this in a *general* way; I promise you that it gets easier to admit mistakes as time goes on. Still, there is a specific strategy to learn for reattunement with each adolescent. Just like the mothers in Tronick's research, we'll have to figure out through trial and error as we go along together in that *particular* intersubjective dance.

Open Spaces

It's hard to imagine a more awkward silence than the one between a therapist who has run out of questions for an adolescent who has nothing to say. Try to match tempo and body with the teen, and then maybe even try to slow it down further, if you can. For adolescents who tend to be very talkative, opening quiet spaces between topics often gives the affect a chance to catch up with the language. For quieter kids, the silence holds respect and

conveys, "I accept you as you are." Some adolescents are so used to fending off adult inquisitions, they are on guard before we ask our first question. We can provide a corrective relational experience by being less intrusive, perhaps clearing the way for them to come toward us.

Consider also whether the moment of quiet is possibly an invitation to head inward; or whether you can cultivate a silence that's simply peaceful and connective, if only for a blink or two. I once worked with a girl for the better part of a year. After we'd gotten to know each other, we often sat in amiable quiet for a few minutes here and there. One winter day, cozy under a blanket, she stretched and sighed loudly before saying to me contentedly, "You know, Marti, this is the only place I can just be me with someone else." I'd been a little worried that I should be doing more than just sitting there. Truthfully, though, for many of us, including me, it's really hard work staying present without the distraction of conversation or an activity to do. Many of us have the skeptical editorial voice in our heads that booms, "What are you going to write about *this* session? What will your supervisor say when she hears this silent tape? You're getting paid to pay careful attention to a kid daydreaming under a blanket? And the objectives of this hour are what, exactly?"

We have to make plenty of room for the right brain to show up. And it's worth it because, as you'll come to see, affect and unconscious material tend to be quite responsive to silence. Talking can let us into an adolescent's world, of course, but it can also keep us far, far away.

Stay Connected

Pay attention moment-to-moment to any information that might facilitate or repair connection. We can work to be increasingly aware of all the unconscious (and conscious) information transmitted in the experience of being together—between our bodies in a glance, a gesture, a slight alteration of movement or facial expression, revealed so fleetingly that we may not be sure we caught it. And we're likely to flat-out miss those micromoments of attunement if we're just paying attention to verbal content. Luckily for the development of the therapy relationship, we'll usually get quite a few opportunities to make adjustments, even within the single hour, when we start noticing more carefully.

But you'll know it when it happens: shifts in empathy and attunement alter connection in an instant, and they can define a session more than all the processing of the other forty-nine minutes. The knowing grab of the eye, a shared chuckle, the turning toward or away, the change in breathing, focus, or body activity—we can take note of it all, commenting or questioning now and then, though not all the time, and only when we can offer our observations in the spirit of collaboration and curiosity.

In common with some other experiential- and relational-based treatments, DRT values the therapist's commitment to "unflinching empathy" (Marotto, 2003). It's vital to this connection with traumatized teens. Such empathic responding helps us pay attention to moments when our clients' arousal is overwhelming, or when they are feeling too vulnerable and begin to dissociate. Empathically make room, and give language to some of the feelings that they have warded off as too dangerous or dysregulating to experience on their own.

Notably, you don't have to attend in some special way just to distressed or negative emotions. In fact, for many of these adolescents, the novelty of happiness, pride, gratitude, delight, or even simple connection can be as destabilizing and anxiety provoking as the bad feelings, if not more so. When strong attachment-based feelings have become associated with traumatic loss, the good ones can become an even greater threat, too, perhaps experienced as both alien and dangerous.

Offer simple reflections about what you notice or about might be happening in their bodies. Try to avoid asking too many questions, especially if you can figure out how to make a nonjudgmental, empathic observation instead. Questions can feel disconnecting and invasive to a traumatized teen. By contrast, a tentative, compassionate response can keep them close, help to co-regulate, and give them the words they don't necessarily have to label their complex emotional experiences. We might say, "That sounds really scary"; "It looks like you're holding yourself tightly right now"; "That must be so painful—not knowing who is on your team"; "I sometimes wonder if you've felt lonely like this for your whole life"; "It sounds like a part of you hates him"; "I imagine you might be pretty upset that you couldn't count on her when you needed her"; "I'm guessing you might feel sort of resentful or let down hearing that bad news"; "I think a lot of kids in this situation would be pretty mad, too."

If you want to ask a feelings question, you can do it more connectively by emphasizing that you're just wondering: "Maybe you feel . . . a little sad about this?" Or ask it in such a way that you're inviting both affect and naming (the whole brain): "Of all the things that worry you, what worries you the most right now?" In any event, try to keep your stance a little curious and tentative—no one likes to be told how she feels, probably least of all a traumatized adolescent. And keep guessing, offer a few possibilities, and prepare to be wrong. It's been my experience that some adolescents say that I'm clueless when I'm spot on; others have no idea how they feel, or what the word is to describe it, and they benefit from the labeling itself. And, best of all, when I've guessed and named the experience just so, in a way that resonates deeply, the adolescent gets to feel felt.

Be the Adult

The therapeutic relationship here is both real and transferential. Thus DRT with traumatized adolescents requires that we make sense of who we are to the teen, both as our authentic adult selves and as stand-ins for all the other adults they have ever known or needed. And DRT is more complicated because we quite literally may engage in "re-parenting" relationships with these adolescents (and sometimes their caregivers), although we clearly know that we are not their parents. We try to appreciate how the adolescent client views us on these multiple levels, and we try to step up willingly and intentionally as the only grown-up in the room—if not in their whole intimate lives.

Devaluing our importance to them as caring adults might be humble or efficient, or fit theoretically into more manualized paradigms that "anyone could do." It might somehow get us off the hook—write off a therapy that goes less well than we wanted, or say good-bye without pain, and forget them more easily. Still, this stance really reflects a kind of *childism*; we can too readily reduce ourselves to the role of technician, or interventionist, and keep the work from getting "too personal." But these teens are not going to get generically healthier, as if there were any such thing as "generic health"; they are going to grow up to become more like us. They will learn about love, repair, problem solving, and what regulation feels like from how we do these things—from how we live in the world, and from being in this specific, unique relationship between a vulnerable child and a caring adult.

And so it makes no sense to be neutral with the same equanimity with which we're trained to treat adults. Yes, our adolescent clients are sharing deeply personal information with us, and we know how fast we lose contact when we start judging and preaching. But they are also telling us stuff so that we'll react to it. We have an obligation of sorts to share our experience of being with them—from the unique vantage point of perceiving them with our adult senses.

Our self-disclosure is carefully considered and must always be offered in the service of the treatment. We describe *our* experience of them, to help *them*. We might want to say, "I'm feeling really worried about you right now because you're not being safe"; "This is frustrating for both of us. I wonder what we could each do to make it better"; "I'm very proud of you. Did you know that?"; "I'm a little anxious about telling you the answer is 'No' because I imagine you'll be very disappointed"; "If I were in your shoes, I'd be confused, too"; "It's been a long time since I was your age, but maybe my experience with bullying might be helpful"; "It's your choice, and I wasn't invited to that party so I won't be there, but can I tell you what I think might happen if you go?"; "I'll care about you just the same

whatever you decide, but I wonder if I might suggest something that could help?"; "Of course it's true, as you say, that the world has changed a lot since dinosaurs roamed the earth, back when I was sixteen, but I've learned a lot about broken hearts in all that time, and I still believe that having your heart broken never stopped being excruciatingly painful"; "I remember what happened the last time, so I wonder if I could make a prediction here"; "I know it feels terrible now, but I'm pretty hopeful that it won't always hurt this much"; "You are one of the bravest kids I've ever met."

Be Kind

Sometimes when I supervise graduate students, I see them getting tangled in theory and in their own heartfelt desire to say or do the perfect, healing thing. These neocortical distractions pull them up into their own heads and out of relationship. They may take on an officious, helpful tone, or the deliberate mannerisms of someone trying to sound like a grown-up or, worse, a therapist. My eager students offer psychoeducation and interpretation, or they ask for information about tangential elements of a complex narrative, just to keep the conversation going along the surface. They are thoughtful and hardworking; none of this effort is particularly harmful. But I want them to get out of their heads and into the room when they start feeling disoriented or preoccupied about what to say next, too. So I suggest this to them: "If you don't know what to say or do, just be kind. You can even ask yourself, 'What would a friend need?'"

Therapists are under a lot of pressure to do something transformative in every session, to fix whatever in the room seems broken, to make it better fast. Sometimes this desire stems from expectations of supervisors or insurance companies, or simply from compassion for desperate parents or frighteningly dysregulated teens. Before you try to do anything else, though, frontload empathy and validation; indeed, empathy and validation may be all that are needed in this moment. It never hurts to be kind. And no matter what we do next, first we must make the limbic connection that lets our adolescent clients know that we get how hard this is for them, and that we respect that. If it were easy to fix, they would have done that already. If you don't know what to do, listen fully—allow yourself to feel for and with them. Be kind. For these kids, that's an intervention.

Keep Guessing about Emotions

In DRT, the therapist tries, to the extent it is possible, not to ask a traumatized teen, "How did you feel about that?" We know all too well that most kids just can't answer that question, but many of us keep hoping otherwise. In most situations, it's more effective to guess and wonder about feelings,

even if you aren't so sure yourself. Help them find the names for what they might be experiencing by simply speculating. Offer some ideas and be prepared to be wrong: "You seem kind of worried, or maybe angry; is that right?"

Name the cues that you're picking up on that led you to make the guess you did: "Okay, maybe you're not mad, but your hands are in fists and you're yelling pretty loudly, so I wonder what is going on." You might also normalize the feelings so you convey acceptance, and stay away from shaming: "I hear you tell me you don't feel mad, but I can understand how someone would be mad if they didn't think people were listening." You can also generalize, to keep the naming in the room but deflect it a bit: "A lot of kids I know get sad in this situation." Or, as I discussed above, you can always use your own experience in the service of the therapy: "I think that if this happened to me, I'd be pretty frustrated and angry." Remember that the goal is to listen, observe, be curious, and guess as compassionately as you can. People still want to "feel felt" even when they don't have the vocabulary, or don't really know how they're feeling.

Go Deep into the Small Details

Adolescents live in the small details of their lives. In many ways, all of us do. But the teen who does not yet have formal operational thought is learning very directly through her daily experiences. Real events, when shared so they are practically relived in the therapy room, provide the adolescent with the opportunity to be both the subject and the object of her own story; she gets to see, hear, and feel what happened to her in the recounting, and to experience herself as interesting, and worthy of your interest. In this way, a detailed account of a seemingly small event expands and takes shape with the support of an affectively engaged and curious therapist. This kind of sharing of experience also helps it make emotional and logical sense.

See what happens when you stop trying to "do deep work" and instead explore actual events in as much minute detail as the teen can handle. There is meaning everywhere, even in the lunchroom at school or on the hair-soaking walk along a rainy street to your office. We get so confused by content and by whose agenda we need to serve in a given hour. My advice is usually to go with the flow; don't be worried if you are "just" talking about another fight with another ex–best friend. If that's what's most readily available, see what happens when you go all the way in, with your heart and mind fully engaged.

Help your adolescent client collect and connect the dots formed by seemingly superficial data points by expanding on each one. Lean forward and ask what people were wearing, where they sat, what happened first, who else was there? Find out what happened before and what next, and

try to bring affect along. Say, for example, "You said *that*? Wow. What did he do when he heard it?" Stay involved with both physical and verbal attunement. Let her story get to you so you can share in authentic feeling: "That's incredible! You're kidding me!"; "That Department of Motor Vehicles lady didn't know who she was dealing with!" Ask for a demonstration if the story has some elements of physicality in it: "Show me how you walked away instead of fighting"; "Act out for me how she wagged her finger in your face"; "Can you do both parts?"; "Can I take the part of the DMV paper pusher so I can really feel your frustration in that interaction?"

Keep the details going until there aren't any more. Don't change the subject until the story is told as completely as possible. If you feel ready to wrap it up, you can make a very quick interpretation, but do not linger on it unless you never want to hear another detailed story. Say, for example, "It sounds like a lot of people gave you a hard time today." Tenderly name a dominant affect: "I'm sorry you had to endure so much frustration all in one afternoon"; "It can be really hard to concentrate in school when there's a fight at lunchtime"; "That is a lot of sadness, and it was hard to talk about maybe because part of you just wanted to forget it." Express gratitude: "Wow, that sounds like some dinner you had, and what an amazing storyteller you are—I feel like I've just had a delicious meal!"

Be Playful

Trauma therapy is, much too often, serious business. When we think about "doing trauma work," we may assume—incorrectly—that it shouldn't be fun or playful. Remember, these are not adults we are dealing with, and our young clients probably didn't get much time to "just be kids" before they hit adolescence, making them less resilient now. Neglect and abuse not only interfere with secure attachment, but also with the behavioral system of exploration and play. Without a secure base, the capacity to play gets compromised; traumatized children can't manage the wide range of arousal states or the level of undefended absorption that play requires. The unpredictability and novelty of play may be too evocative of the unpredictability and danger of earlier traumatic experiences. Furthermore, it might be that some of our adolescent clients don't play because they've come to associate positive affect with vulnerability to ridicule, disapproval, disdain, or even punishment. All affective states, including the ones that we might associate with a fun time, have their perils for these adolescents.

In DRT, then, don't just pay attention to the trauma story and attachment-related issues; look for opportunities to engage more playfully, too. These may be just micro "now moments" where eyes meet and knowing smiles are exchanged, moments that offer the possibility for more expansive, enjoyable times, too. Linger on a guffaw, laugh at yourself (but never

at the teen, unless you are laughing together and he clearly gets his own joke), expand on something that seems ironic, comical, or just mildly amusing. Notice when the connection feels lighter, or something tough has been accomplished; relief can feel good, too. Laughter is an attachment-based affect, and it can be good therapy to share such joy.

We want our traumatized clients to develop a much broader platform on which to build their emotional hardiness. The window of tolerance needs to accommodate pleasure and spontaneity as well. As Allan Schore (2003) writes, "Affect regulation is not just the reduction of affective intensity, the dampening of negative emotion. It also involves an amplification, an intensification of positive emotion, a condition necessary for more complex self-organization" (p. 78).

For adolescents who struggle to see the good time in traditional talk therapy, and are rigidly defended against playful movement or banter, I often like to include play-based activities that involve turn taking or mutual focus, particularly ones that can get a tiny bit messy, or give me the chance to be amused with what's happening (Straus, 1998). For example, I've treated teens who enjoy building Popsicle stick structures, or capsizing Jenga towers, embarking on epic card games, making sock puppets, and teaching me magic tricks. I'm not above blowing bubbles, balancing peacock feathers, shooting Nerf baskets, playing catch, or doing a jigsaw puzzle if it might be fun, regulating, and connective to do so. I have yet to meet a teen who can resist "Crazy Aaron's Thinking Putty" (a kind of colorful Silly Putty that's pretty much guaranteed to keep anxious hands busy), or the rest of my conveniently placed basket of fidget toys. In the past couple of years, I've also helped make original board games from a kit; one girl I worked with even rebuilt the board game "Guess Who" using pictures of kids from school, telling me all about these classmates as we constructed it. You don't *have to* play or goof around with your adolescent clients, of course, and many don't want to, but you *can*. While therapy with traumatized teens is often really hard, sad, wrenching work, it needs to be more than that, too, so they can live fuller, happier, more integrated lives when we're done. And don't forget: we're successful when our clients feel co-regulated at the end of a therapy hour, any way we help get them there.

JAMES REVISITED

I had to hospitalize James on two occasions. Truth told, I had my eye on him from the start because, a month into our work, he had punched a wall so hard that he broke his hand. Then, that first spring, he was often covered in bruises and scrapes that he attributed to simple carelessness while practicing tricks on his skateboard. He'd had at least one concussion that I knew

about. I worry in a particular way about traumatized kids who have this kind of trouble keeping themselves safe: there's always the likelihood that they might be engaging in dangerous, unconscious reenactments. I came to believe James had a self-destructive streak that developed in response to feeling so unsafe in his home when he was small. He still had trouble keeping his body safe.

About six months into our work, James had, once again, been doing skateboard stunts, and deliberately catapulted himself off a bridge into a deep, cold river. Although, amazingly, he suffered only minor injuries, he was not clear with me about what he'd hoped would happen. When I asked about suicidal intent, James just shrugged and said softly, "Who cares?" I did, of course, and got him an inpatient bed that day. He stayed just a week, though, since he was able to spin the incident as a knuckleheaded teenage act, and convince staff that I'd misunderstood him.

The second hospitalization, about a year later, was more serious. His grandmother, sensing he was more depressed than usual, had checked up on him before bedtime and discovered to her horror that he'd been busy constructing a noose. She quickly brought him to the emergency room. This incident, a more unambiguous suicidal mission, led to a month-long stay in the psych unit. The precipitating events were clear. A few days earlier, James had taken the brave and unusual step of calling Child Protective Services about his own mother. She had been using drugs that day—he was certain—and a couple of scary men had been at her apartment when he got there, maybe one of them was her dealer or a boyfriend; he hadn't met them before. James didn't feel safe and, to my understanding, he wanted her to get help, and maybe go back to having supervised visits. James had told me about his call to the child protection hotline; he emphasized that he'd made the call anonymously. In telling me, James reassured himself that he'd done the right thing, although he was so anxious recalling the experience that he practically whispered.

I expressed my admiration, thinking that the call had been a valiant bit of self-advocacy. I was concerned by what might follow this turn of events after our session, but he seemed angry and fretful, not suicidal. And he was standing up for himself for the first time. In hindsight, perhaps I should have been more worried; in many years of practice, I can't recall another time that a teenager reported his own mother to social services. I readily grasped that there might be fallout he hadn't considered, including more jail time for his mother, but I failed to predict what did happen next.

After leaving my office, James evidently felt increasingly guilty, and he ultimately decided he had to call his mother to tell her he'd been the one to dial the hotline. He'd tried to apologize to her, saying he loved her and wanted her to stop taking drugs. But she'd raged at him as never before, bringing up all the things he most dreaded hearing: he had ruined her life, she never wanted to see him again, he was just like his psychopath father.

Not surprisingly, this nightmarish phone call precipitated a new level of despair for James, and he decided the only way to escape his misery was to hang himself.

The following week, I went to see James on the inpatient unit. Fortuitously, I happened to get there on an afternoon when a couple of therapy dogs were also in the community room. I got to see a side of James that he'd never revealed to me. He was remarkably relaxed, affectionate, and happy down on the floor, rolling around with a golden retriever and talking in a loving, goofy way to the dog. Here was this miserable, isolated boy who had planned to kill himself, and who struggled so hard to connect with other humans, in deep limbic engagement with an animal. I took note and filed away this observation for our next session at my office.

In the interim, and with his grandmother's consent, I contacted a veterinarian friend of mine, Dr. Z., with a proposition. If I could persuade James to give it a try, would Dr. Z. take on the experiment of "hiring" an assistant who loved animals and needed to be of use? He agreed, and a plan was hatched. When James and I met after his discharge, he was diffident about the offer, but he didn't exactly refuse. His grandmother set up a few after-school visits at the veterinary clinic to give it a try.

James came to therapy a week later, after spending his first two afternoons shadowing Dr. Z around the clinic. I immediately noticed that his shoes were now tied, and that he had a different sort of bouncy energy in his gait. This usually taciturn, sorrowful boy proceeded to spend the next hour telling me (in nauseating detail, truth be told, although I only half-complained) about helping to spay a Bernese mountain dog, and tending to the shaved and stitched cat who'd evidently been the loser in a neighborhood fight. While my intervention here was not some kind of magical cure, James now evinced, for the first time, a trace of passion and purpose beyond mere survival. And, there and then, he began to get some traction in his life. Happily, too, Dr. Z. became another important member of James's team of reliable, nurturing adults.

My delight in finding a way to connect with James is important to describe. The stakes are high with high-risk kids, and we are often less helpful than we hope. Had James gone though the cycle of self-destructive behavior, overt suicidality, and hospitalization another few times, I think he would have become increasingly difficult to reach. But even now, years later, as I write about this astonishing young man, I find myself smiling a little. By the time we decided to take a break, James had left school and was working toward his GED. He'd gotten a job as a dog groomer in a big pet store at the mall, and he had even started amassing his own loyal clientele. I am proud of that young man. And so here's the thing about DRT: it is the kind of therapy that, when we're really connecting deeply with a teen, makes *us* stronger, too.